Federal Department of Justice Finds Violations of the Constitution and ADA at Lanterman Developmental Center: 1-4-06 Findings Letter

The federal Department of Justice (DOJ) recently investigated the Lanterman Developmental Center, issuing a Letter of Findings on January 4, 2006 which found that the Constitutional and ADA rights of the residents of Lanterman were violated and identified minimal remedial measures.[1] Violations or residents rights to community integration and dangers to residents' health and safety were identified.

Failure to Integrate Residents into the Community

DOJ found systemic violations by DDS and the regional centers in discharge planning at Lanterman. It concluded that the state had failed to adequately carry out its legal obligations to provide institutionalized Lanterman residents with services and supports in the most integrated settings appropriate to their needs, in violation of Title II of the ADA and Section 504 of the Rehabilitation Act of 1973.

IPP Violations

DOJ found that Lanterman DC has failed to follow its own policies and has inadequate policies and practices with regard to the development and implementation of Individual Program Plans (IPPs) and discharge planning. DOJ determined that the IPP process was generally inadequate with regard to addressing residents' need for placement in the most integrated setting, as;

- Critical regional center personnel often do not attend annual IPP reviews, thus thwarting any meaningful discussion of community alternatives;
- In-depth community service assessments are not conducted for all Lanterman residents;
- Teams fail to make and memorialize a considered determination on proper placement and whether or not the person opposes such placement; and

[1] Pursuant to the Civil Rights for Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq., the United States Department of Justice has the authority to conduct investigations of the conditions of care for individuals with disabilities who have been institutionalized. DOJ also has the authority to issue plans of correction and seek legal remedies for violations of civil rights of individuals who are institutionalized. 42 U.S.C. § 1997a.

- IPP teams condition recommendations regarding community placement on the current availability of community services, rather than on the needs of the individuals being assessed. p. 43-49.

DOJ's findings are similar to plaintiffs' allegations in *CPF v. DDS* regarding the failures of the IPP process, such as:

- Regional centers' failure to attend IPP meetings;
- In-depth community assessments are not conducted for all Lanterman DC residents;
- Systemic failure to conduct timely and comprehensive assessments necessary to identify the services for which class members are eligible and that could meet their needs in less restrictive, more integrated community settings; and
- IPP teams' conditioning recommendations regarding community placement on the current availability of community services, rather than on the needs of the individuals being assessed.

The Number of People Dying at Lanterman Was Greater Than the Number of People Moving to the Community

DOJ further found a reduction in the number of individuals moving from Lanterman to the community in recent years, noting that more people died at Lanterman than moved to the community. p. 44. These findings are similar to plaintiffs' allegations in *CPF v. DDS* that the decrease in community movement recommendations since 1998 is based not on the needs and choices of the individual residents but, rather, on the lack of a mandate from DDS, inadequate individualized IPP planning by regional centers and DC staff, and/or lack of sufficient fiscal resources for the development of quality living arrangements and ancillary supports.

Minimal Remedial Measures

DOJ identified the following *minimal* remedial measures to provide services to individuals with developmental disabilities in the most integrated settings appropriate to their needs:

- Conduct interdisciplinary assessments with people who have adequate information about community-based options;
- Develop and implement transition plans for individuals who want to move to the community and for whom a more integrated setting would be appropriate;

- Develop and implement a protocol to address outstanding issues and concerns with the State's regional centers that may impede, limit, or delay placement of residents into more integrated community settings, and
- Reform the IPP process to better ensure that the teams make informed and proper decisions with regard to the most integrated setting for each resident. p. 55-56.

Failure to Provide Safe Living Conditions & Adequate Treatment

DOJ found that Lanterman fails to provide its residents with a reasonably safe living situation. Between 2003 and 2004, at least 275 allegations of abuse and neglect against residents were made. The most horrifying incident occurred in 2002, when A.Z. "died of blunt force trauma after being stomped repeatedly in his bedroom at Lanterman." There was evidence that both the roommate and a psych. tech. were responsible, but the psych. tech. was not charged and the roommate was found to be too mentally impaired to be charged. p. 4.

DOJ found that residents regularly face harm in their day-to-day lives. Between 2003 and 2004, there were 1,681 incidents, of which 233 were lacerations (61 requiring sutures) and at least 67 were fractures. Some residents sustained genital lacerations, a topic that has been the report of a recent PAI public report. DOJ felt that it was unclear how so many serious injuries could occur at a facility responsible for keeping residents safe, but expressed particular concern that the causes of the injuries were, in so many situations, found to be "unknown," suggesting lack of safety and lack of appropriate supervision. DOJ found a number of problems regarding the incident reporting system, including failure to track incidents, failure to report incidents in a timely manner, and adequacy of incident investigations.

Training and Behavioral Services, Restraints, and Psychiatric Care

People with developmental disabilities who reside in institutions have a right to minimal adequate training.[2] 229 Lanterman residents with behavioral problems received training and associated psychological and behavioral services through a formal behavioral program. But Lanterman fails to provide adequate, appropriate services. DOJ found that "[t]his deficiency contributes to poor resident outcomes, including poor progress in treating problem behaviors, increasing risk for highly

[2] *Youngberg v. Romeo*, 457 U.S. 307, at 322 (1982).

restrictive interventions, increased risk for injury and abuse, and decreased opportunity for placement in the most integrated setting." p 12.

The following is an example of a client who was poorly served by Lanterman:

"H.A. is a 27-year-old man who was admitted to Lanterman at age 13 for treatment of his behavior problems. However, it does not appear that the facility has made much, if any, progress in addressing his behavior over the past 14 years. During his stay at Lanterman, he has developed serious self-injurious behavior, such as hitting his head. Through self-injury, H.A. recently detached the retina in one of his eyes. Between January and October 2004, as a result of his uncontrolled behaviors, he has also suffered seven other significant injuries. Prior to the hospitalization for his detached retina, H.A. averaged between 139 and 357 episodes of self-injurious behavior each month. Between January and October 2004, staff imposed 5644 highly restrictive interventions on him. … His behavior program includes the use of a helmet and arm splints. He also receives three separate psychotropic medications. Despite the magnitude of his injuries and the high rate of use of highly restrictive interventions, Lanterman failed to update or change his behavioral assessment or behavior treatment plan at any time during this period. Generally accepted professional standards mandate that this should have occurred. *Moreover, his team has not recommended H.A. for placement in a more integrated setting because of his high rate of uncontrolled behaviors. Thus, the facility's failures may be prolonging his behavior and may be denying him access to placement in a more integrated setting [emphasis added]."* p. 12.

Health Care Services

DOJ found that Lanterman failed to provide residents with adequate medical care. General medical care and nursing care were found to be deficient, both in terms of direct services and in terms of oversight. The lack of nutritional and physical management and lack of adequate occupational and physical therapy services "place residents at great risk for injury or death." p. 29.